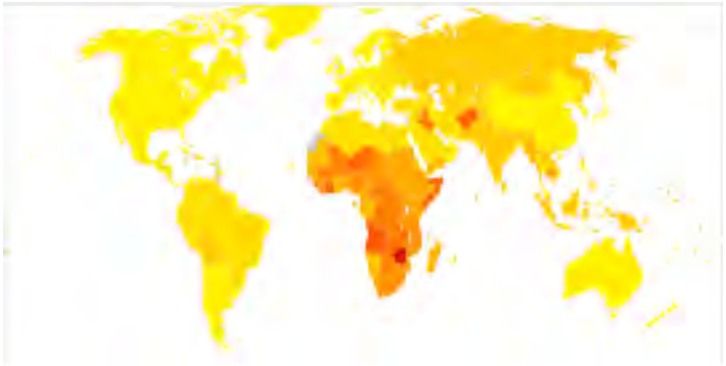

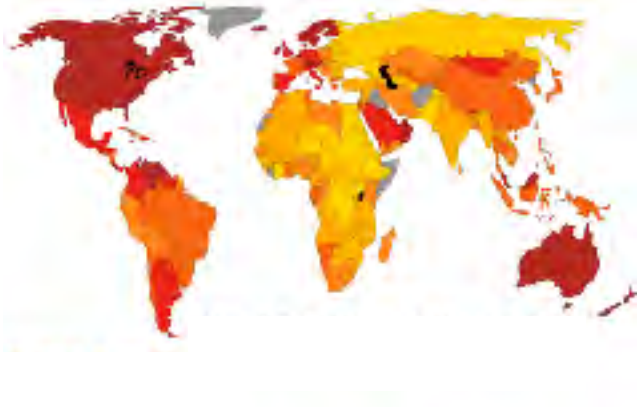

Global Mental Health: A Critical Introduction

Laurence J. Kirmayer, MD, FRCPC, FCAHS, FRSC

James McGill Professor & Director
Division of Social & Transcultural Psychiatry
McGill University
Culture and Mental Health Research Unit
Jewish General Hospital

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Jewish General Hospital

Home
History of the Division
Activities
Research
Training
Clinical
Faculty
Students
Publications
International Projects
Network
Resources

The Division of Social and Transcultural Psychiatry is a network of scholars and clinicians within the Department of Psychiatry, Faculty of Medicine, McGill University, devoted to promoting research, training and consultation in social and cultural psychiatry.

The broad themes of research and training conducted by members of the Division include:

Social Psychiatry

- psychiatric epidemiology
- social causes and consequences of psychiatric disorders
- psychiatry in primary care
- social treatments, rehabilitation and prevention strategies
- evaluation of services

Cultural Psychiatry

- mental health of indigenous peoples, ethnocultural minorities, immigrants and refugees
- international community mental health
- indigenous healing practices, ethnopsychology and ethnopsychiatry
- cultural critique of Western psychiatric theory and practice

www.mcgill.ca/tcpsych

WHAT'S NEW

April 10, 2013

Cultura Psychiatry Day

Aboriginal Mental Health Resilience and Empowering Models of Care

VIDEO SERIES

Video teachings from 2012 Summer School Program

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Rachel Tribe on working with interpreters in mental health

DIVISION ACTIVITIES

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Transcultural Psychiatry
A scientific journal

Global Mental Health Program | Programme mondial pour la santé mentale

Mission Statement

The McGill Global Mental Health Program (GMHP) is a multidisciplinary research and training hub based at the Department of Psychiatry in the Division of Social and Transcultural Psychiatry. The program is dedicated to the advancement of knowledge and action research on mental health disparities around the world, especially in low- and middle income countries (LMIC).

GMHP promotes a multi-disciplinary research agenda with a particular focus on bringing the social science's perspectives to bear on the understanding and response to mental health problems internationally. Building on McGill's longstanding tradition in cultural psychiatry and the university's excellent mental health research community, the Global Mental Health Program creates a collaborative space and training environment through

- Multi-disciplinary action research
- Platforms for dialogue and networking (GMH seminar series & film series)
- Training opportunities for students (e.g. annual summer school)
- Capacity building (across Canada & in LMICs)
- Knowledge exchange and translation

CONGRATULATIONS to the 2017 Duncan Pedersen Graduate Award winner, Helen Martin.

EVENTS & NEWS

International Course on Cultural Psychiatry & Global Mental Health

October 16-17, 2017

Kathmandu, Nepal

NEXT SPEAKER

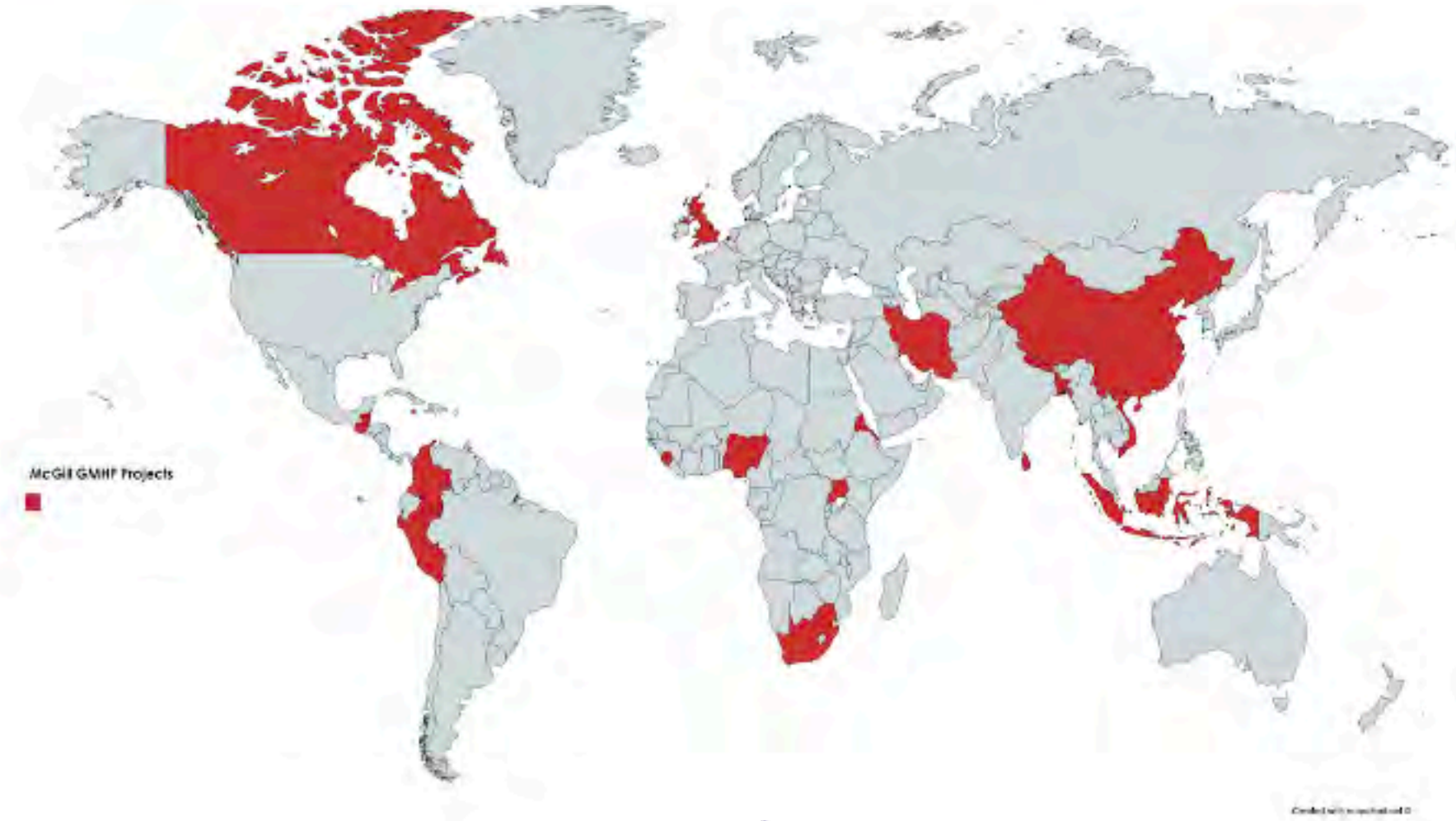
Ingrid Weldon, PhD

November 23rd, 2017, 3-4:30pm

Dep. of Psychiatry (Ludmer), 1033 Ave Pine, room 1

Global Mental Health Program

Programme mondial pour la santé mentale



McGill | GLOBAL HEALTH PROGRAMS | PROGRAMMES DE SANTÉ MONDIALE

Outline

- global mental health and the Movement for Global Mental Health
- the logic of GMH: psychiatric epidemiology, DALYs and disparities
- the practice of GMH: mhGAP and task shifting
- Grand Challenges for GMH
- critique of GMH
- culture and context pluralism and forms of knowledge
- example of mental health promotion with Indigenous communities in Canada
- implications for research, training and practice

No health without mental health

Martin Prince, Vikram Patel, Shekhar Saxena, Mario Maj, Joanna Maselko, Michael R Phillips, Atif Rahman

About 14% of the global burden of disease has been attributed to neuropsychiatric disorders, mostly due to the chronically disabling nature of depression and other common mental disorders, alcohol-use and substance-use disorders, and psychoses. Such estimates have drawn attention to the importance of mental disorders for public health. However, because they stress the separate contributions of mental and physical disorders to disability and mortality, they might have entrenched the alienation of mental health from mainstream efforts to improve health and reduce poverty. The burden of mental disorders is likely to have been underestimated because of inadequate appreciation of the connectedness between mental illness and other health conditions. Because these interactions are protean, there can be no health without mental health. Mental disorders increase risk for communicable and non-communicable diseases, and contribute to unintentional and intentional injury. Conversely, many health conditions increase the risk for mental disorder, and comorbidity complicates help-seeking, diagnosis, and treatment, and influences prognosis. Health services are not provided equitably to people with mental disorders, and the quality of care for both mental and physical health conditions for these people could be improved. We need to develop and evaluate psychosocial interventions that can be integrated into management of communicable and non-communicable diseases. Health-care systems should be strengthened to improve delivery of mental health care, by focusing on existing programmes and activities, such as those which address the prevention and treatment of HIV, tuberculosis, and malaria; gender-based violence; antenatal care; integrated management of childhood illnesses and child nutrition; and innovative management of chronic disease. An explicit mental health budget might need to be allocated for such activities. Mental health affects progress towards the achievement of several Millennium Development Goals, such as promotion of gender equality and empowerment of women, reduction of child mortality, improvement of maternal health, and reversal of the spread of HIV/AIDS. Mental health awareness needs to be integrated into all aspects of health and social policy, health-system planning, and delivery of primary and secondary general health care.

Lancet 2007; 370: 859–77

Published Online
September 4, 2007
DOI:10.1016/S0140-6736(07)61238-0

This is the first in a **Series** of six papers about global mental health

See **Comment** page 806 and page 810

See **Perspectives** page 821

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Introduction

The WHO proposition that there can be "no health without mental health"[1] has also been endorsed by the Pan American Health Organisation, the EU Council of Ministers, the World Federation of Mental Health, and the UK Royal College of Psychiatrists. What is the substance of this slogan?

Mental disorders make a substantial independent contribution to the burden of disease worldwide (panel 1).[2] WHO's 2005 estimates of the global burden of disease provide evidence on the relative effect of health problems worldwide.[3,4] Non-communicable diseases are rapidly becoming the dominant causes of ill health in all developing regions except sub-Saharan Africa (table 1).[4] The Global Burden of Disease report has revealed the scale of the contribution of mental disorders, by use of an integrated measure of disease burden—the disability-adjusted life-year, which is the sum of years lived with disability and years of life lost.[4] The report showed that neuropsychiatric conditions account for up to a quarter of all disability-adjusted life-years, and up to a third of those attributed to non-communicable diseases, although the size of this contribution varies between countries according to income level (table 1).[4] The neuropsychiatric conditions that contribute the most disability-adjusted life-years are mental disorders, especially unipolar and bipolar affective disorders, substance-use and alcohol-use disorders, schizophrenia, and dementia. Neurological disorders (such as migraine, epilepsy, Parkinson's disease, and multiple sclerosis) make a smaller but still significant contribution. Of the non-communicable diseases, neuropsychiatric conditions contribute the most to overall burden (figure 1 and table 1),[4] more than either cardiovascular disease or cancer.

Search strategy

We searched relevant databases (Medline, PubMed, Embase, and the Cochrane Library of systematic reviews and clinical trials) with the following Mesh terms: "mental disorders", "substance-related disorders", "cardiovascular diseases", "cerebrovascular disorders", "diabetes mellitus", "diabetes complications", "HIV infections", "malaria", "tuberculosis", "genital diseases", "female", "infant nutrition disorders", "and accidents", together with the PubMed clinical queries algorithms for aetiology, prognosis, treatment, and systematic reviews. For non-communicable disorders (coronary heart disease, stroke, and diabetes), and communicable disorders (HIV/AIDS, tuberculosis, and malaria) we focused on index conditions that are especially salient to public health. We concentrated on papers published since 2000, and have prioritised evidence from low-income and middle-income countries and from systematic reviews and meta-analyses. We have cited subsequent publications if they provided new information.

About the movement

The Movement for Global Mental Health is a network of individuals and organisations that aim to improve services for *people living with mental health problems and psychosocial disabilities worldwide*, especially in low- and middle-income countries where effective services are often scarce. Two principles are fundamental to the Movement: scientific evidence and human rights.

The history of the Movement began in 2007 with a Call for Action published in the first Lancet series on global mental health. Through volunteerism and

Media

5 OCTOBER 2014

The 'better' prognosis hypothesis' for schizophrenia in poor countries. Is it the medication?

10 SEPTEMBER 2014

INTERNATIONAL LEADERS UNITE UNDER #FUNDAMENTALSDG TO CREATE GLOBAL MOVEMENT IN INCLUSION OF MENTAL HEALTH IN THE UNITED NATIONS (UN) POST 2015 DEVELOPMENT AGENDA

23 AUGUST 2014

Mental health: a world while goal

11 AUGUST 2014

Broken Light: A Photography Collective-Embracing The Depression

Latest activity

28 OCTOBER 2014

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23 AUGUST 2014

Including mentalhealth among the new sustainable development goals added to Resources

22 AUGUST 2014

A position statement on mental health in the post-2015 development agenda added to Resources

3 JULY 2014

Global Mental Health Trials added to Resources

25 JUNE 2014

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Join and add your logo to our site

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Cross-Cutting Themes & Issues

- Global mental health exists against the historical background and ongoing reconfigurations of colonialism, postcolonialism, neocolonialism, and the contexts of globalization
- psychiatrization and psychologization play an important role in emerging forms of personhood in modernity
- psychiatric institutions contribute to social control, regulation, and legitimation not only through carceral functions but increasingly through epistemic regimes of evidence and authority
- the process of making global mental health a movement aims to mobilize resources but raises a set of new political, organizational and conceptual questions

Logic of the GMH Movement

The GMH movement makes four key moves:

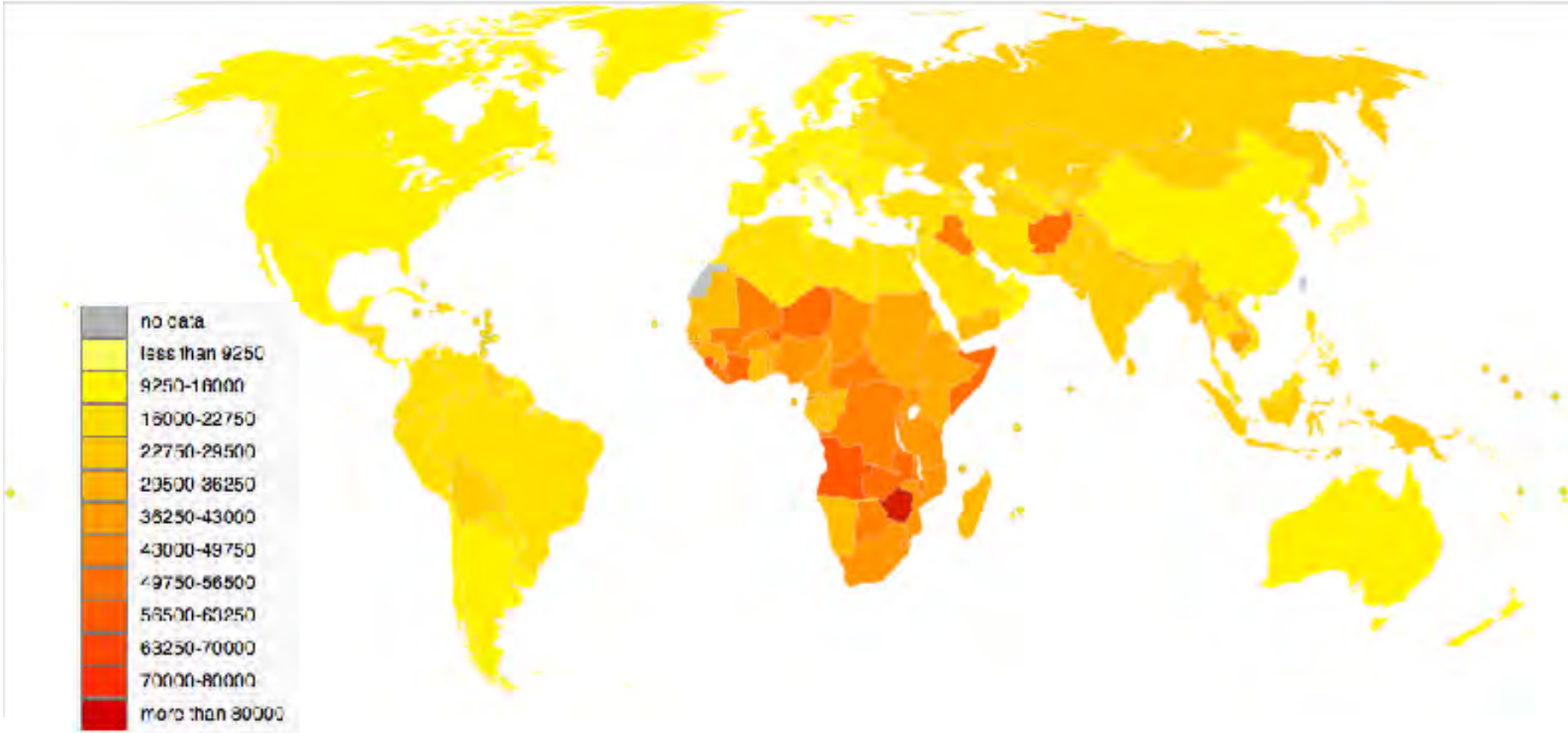
1. documenting the enormous disparities in mental health in low and middle income countries

2. arguing these should be a higher priority in development (not secondary to other public health measures in infectious and communicable diseases

3. framing the disparity in terms of a treatment gap

4. aiming to identify, test, and scale-up evidence-based interventions to meet the treatment gap.

Disability-adjusted life year for all causes per 100,000 inhabitants in 2004



The **disability-adjusted life year (DALY)** is a measure of overall disease burden. Originally developed by the World Health Organization. Traditionally, health liabilities were expressed using one measure: (expected or average number of) **Years of Life Lost (YLL)**. This measure does not take the impact of disability into account, which can be expressed by: **Years Lived with Disability (YLD)**.

DALYs are calculated by taking the sum of these two components. In a formula: **DALY = YLL + YLD**.

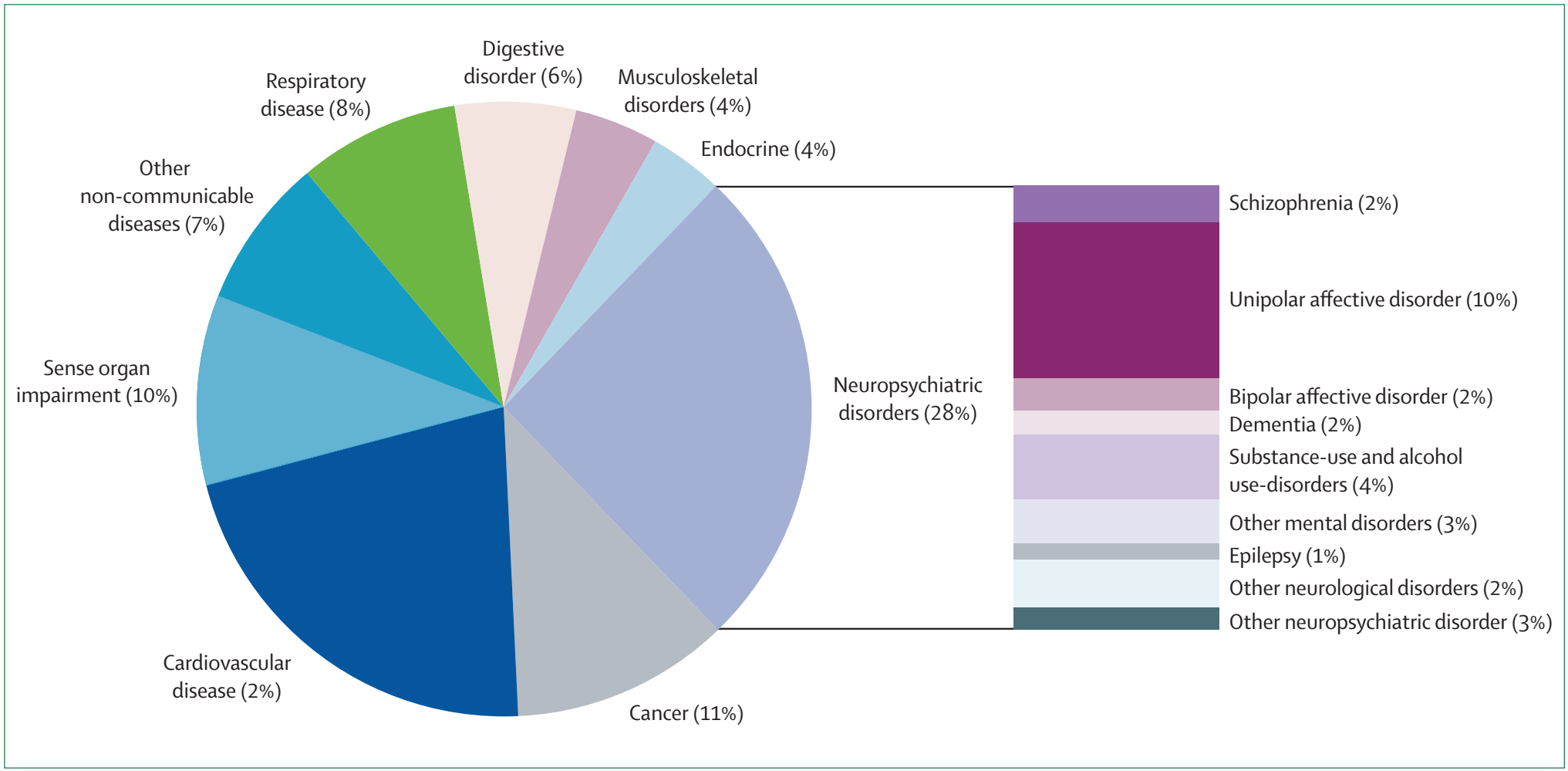


***Figure 1*: Contribution by different non-communicable diseases to disability-adjusted life-years worldwide in 2005**
Data adapted from WHO, with permission.[3]

40. Median number of psychiatric beds per 10 000 population

WHO Regions	Median per 10 000 population
Africa	0.34
Americas	2.60
Eastern Mediterranean	1.07
Europe	8.00
South-East Asia	0.33
Western Pacific	1.06
World	1.69

N = 185

47. Median number of psychiatrists per 100 000 population

WHO Regions	Median per 100 000 population
Africa	0.04
Americas	2.00
Eastern Mediterranean	0.95
Europe	9.80
South-East Asia	0.20
Western Pacific	0.32
World	1.20

N = 187

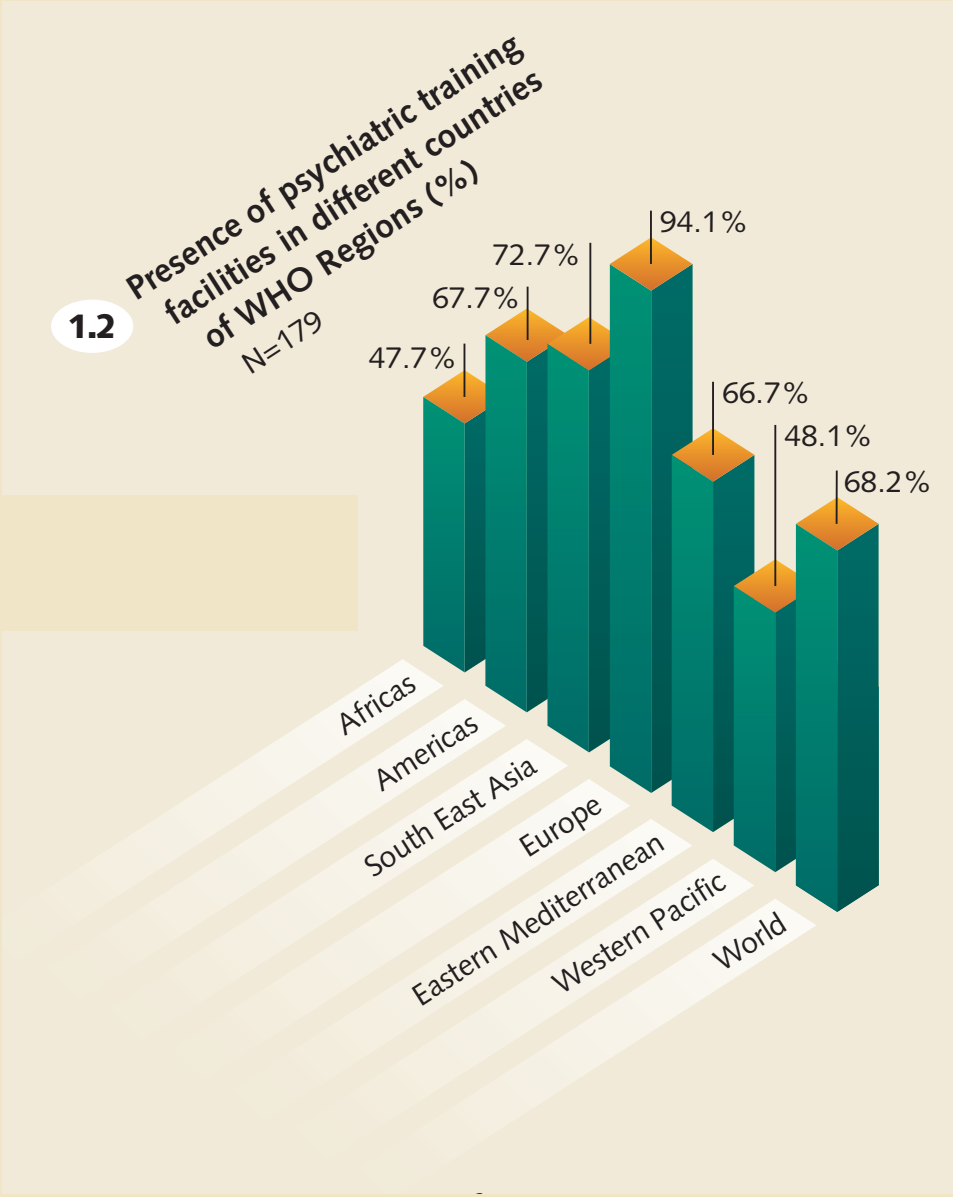


Figure 1: Burden of mental disorders and budget for mental health

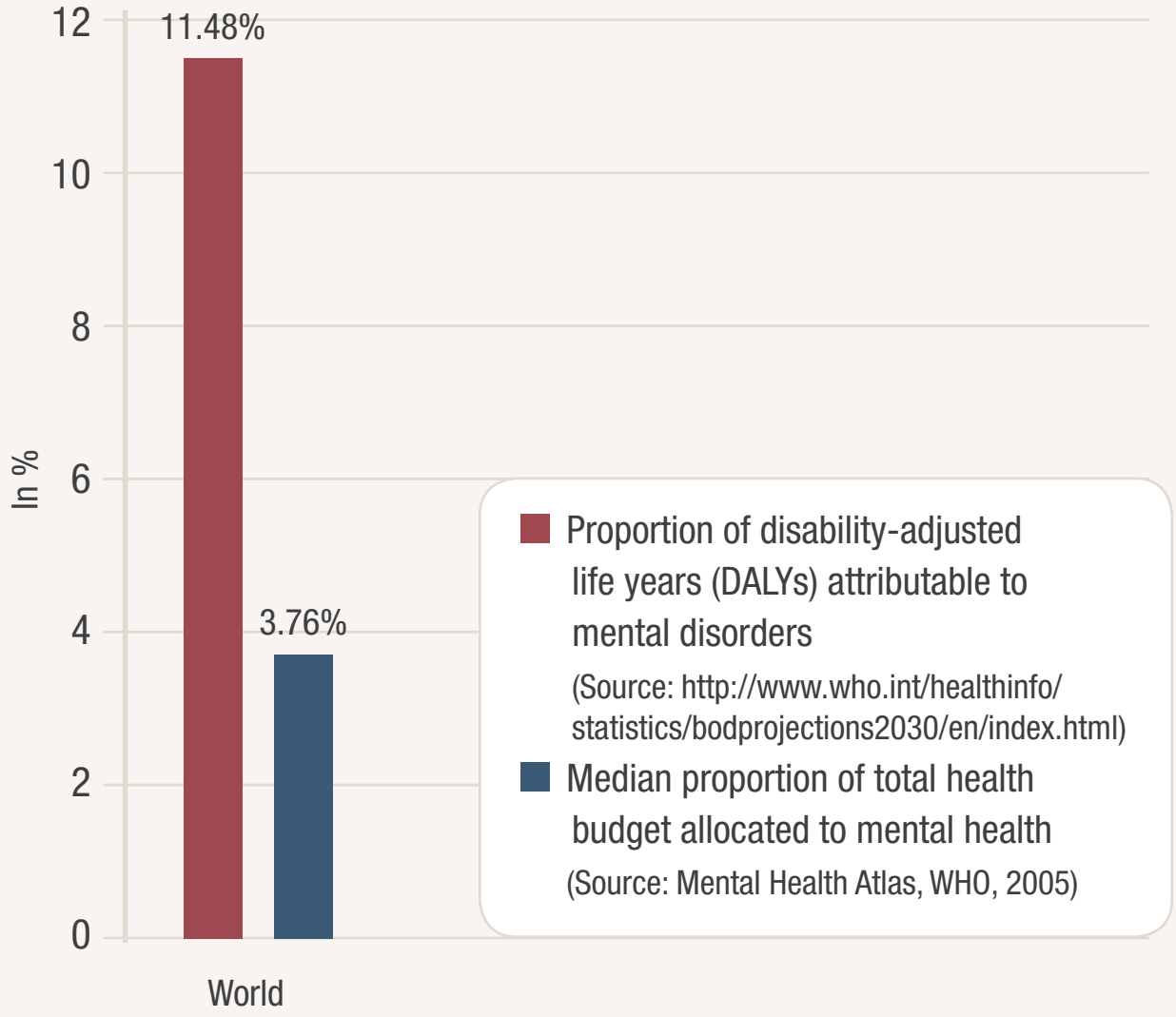
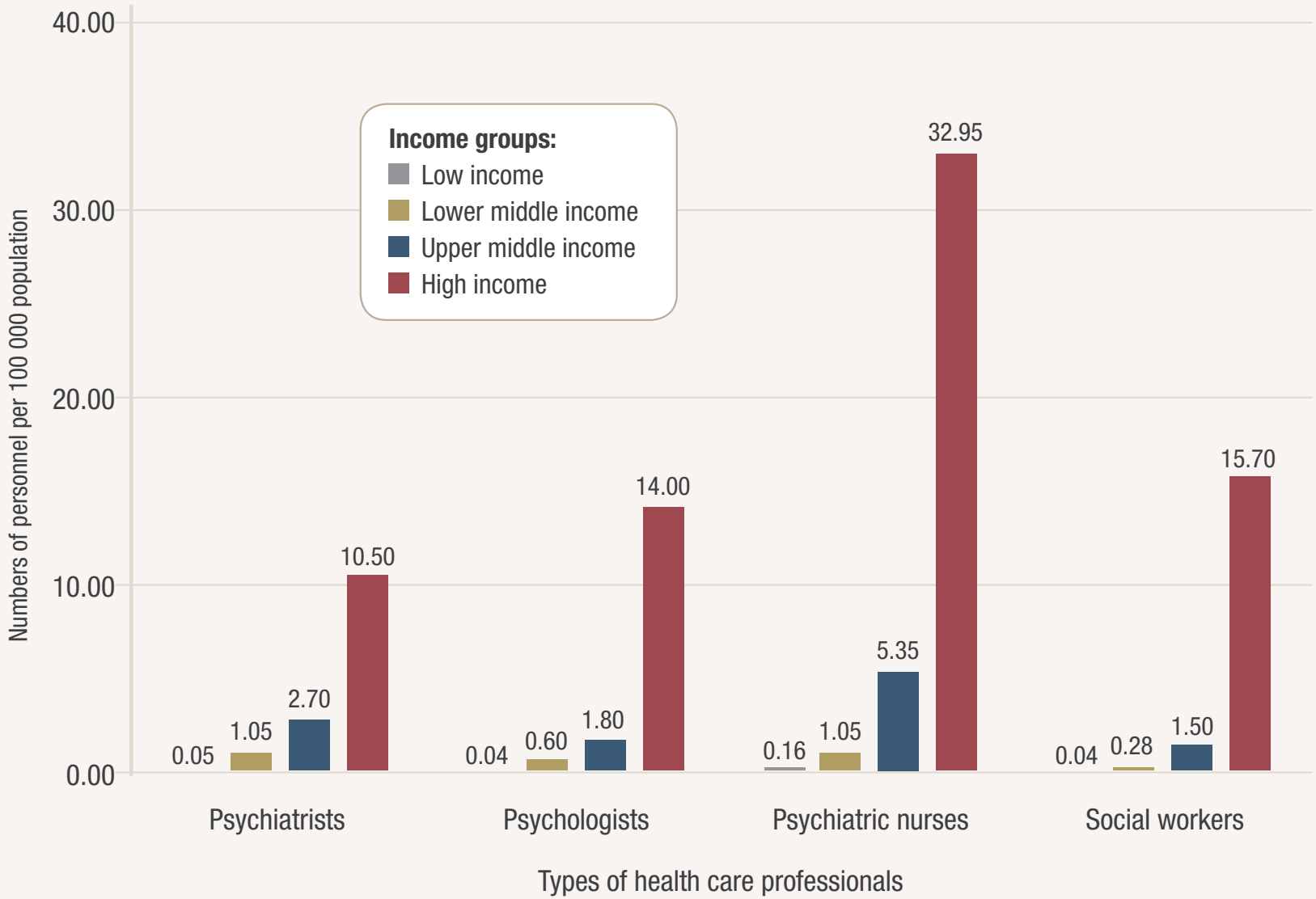


Figure 3: Human resources for mental health care in each income group of countries, per 100 000 population



(Source: *Mental Health Atlas*, WHO 2005)

mhGAP-IG

www.who.int/mental_health/evidence/mhGAP_intervention_guide/en/

mhGAP Intervention Guide

for mental, neurological and substance use disorders
in non-specialized health settings

World Health Organization

mental health Gap Action Programme

mhGAP-IG Master Chart: Which priority condition(s) should be assessed?

1. These common presentations indicate the need for assessment.
2. If people present with features from more than one condition, then all relevant conditions need to be assessed.
3. All conditions apply to all ages, unless otherwise specified.

COMMON PRESENTATION	CONDITION TO BE ASSESSED	GO TO
• Low energy; fatigue; sleep or appetite problems • Persistent sad or anxious mood; irritability • Low interest or pleasure in activities that used to be interesting or enjoyable • Multiple symptoms with no clear physical cause (e.g. aches and pains, palpitations, numbness) • Difficulties in carrying out usual work, school, domestic or social activities	Depression * ^	DEP 10
• Abnormal or disorganized behaviour (e.g. incoherent or irrelevant speech, unusual appearance, self-neglect, unkempt appearance) • Delusions (a false firmly held belief or suspicion) • Hallucinations (hearing voices or seeing things that are not there) • Neglecting usual responsibilities related to work, school, domestic or social activities • Manic symptoms (several days of being abnormally happy, too energetic, too talkative, very irritable, not sleeping, reckless behaviour)	Psychosis *	PSY 18
• Convulsive movement or fits/seizures • During the convulsion: – loss of consciousness or impaired consciousness – stiffness, rigidity – tongue bite, injury, incontinence of urine or faeces • After the convulsion: fatigue, drowsiness, sleepiness, confusion, abnormal behaviour, headache, muscle aches, or weakness on one side of the body	Epilepsy / Seizures	EPI 32
• Delayed development: much slower learning than other children of same age in activities such as: smiling, sitting, standing, walking, talking/communicating and other areas of development, such as reading and writing • Abnormalities in communication, restricted, repetitive behaviour • Difficulties in carrying out everyday activities normal for that age	Developmental Disorders Children and adolescents	DEV 40

- Excessive inattention and absent-mindedness, repeatedly stopping tasks before completion and switching to other activities
- Excessive over-activity: excessive running around, extreme difficulties remaining seated, excessive talking or fidgeting
- Excessive impulsivity: frequently doing things without forethought
- Repeated and continued behaviour that disturbs others (e.g. unusually frequent and severe temper tantrums, cruel behaviour, persistent and severe disobedience, stealing)
- Sudden changes in behaviour or peer relations, including withdrawal and anger

Behavioural Disorders — BEH — 44

Children and adolescents

- Decline or problems with memory (severe forgetfulness) and orientation (awareness of time, place and person)
- Mood or behavioural problems such as apathy (appearing uninterested) or irritability
- Loss of emotional control – easily upset, irritable or tearful
- Difficulties in carrying out usual work, domestic or social activities

Dementia — DEM — 50

Older people

- Appearing to be under the influence of alcohol (e.g. smell of alcohol, looks intoxicated, hangover)
- Presenting with an injury
- Somatic symptoms associated with alcohol use (e.g. insomnia, fatigue, anorexia, nausea, vomiting, indigestion, diarrhoea, headaches)
- Difficulties in carrying out usual work, school, domestic or social activities

Alcohol Use Disorders — ALC — 58

- Appearing drug-affected (e.g. low energy, agitated, fidgeting, slurred speech)
- Signs of drug use (injection marks, skin infection, unkempt appearance)
- Requesting prescriptions for sedative medication (sleeping tablets, opioids)
- Financial difficulties or crime-related legal problems
- Difficulties in carrying out usual work, domestic or social activities

Drug Use Disorders — DRU — 66

- Current thoughts, plan or act of self-harm or suicide
- History of thoughts, plan or act of self-harm or suicide

Self-harm / Suicide — SUI — 74

* *The **Bipolar Disorder (BPD)** module is accessed through either the **Psychosis** module or the **Depression** module.*

‸ *The **Other Significant Emotional or Medically Unexplained Complaints (OTH)** module is accessed through the **Depression** module.*

Psychosis

PSY

Psychosis is characterized by distortions of thinking and perception, as well as inappropriate or narrowed range of emotions. Incoherent or irrelevant speech may be present. Hallucinations (hearing voices or seeing things that are not there), delusions (fixed, false idiosyncratic beliefs) or excessive and unwarranted suspicions may also occur. Severe abnormalities of behaviour, such as disorganized behaviour, agitation, excitement and inactivity or overactivity, may be seen. Disturbance of emotions, such as marked apathy or disconnect between reported emotion and observed affect (such as facial expressions and body language), may also be detected. People with psychosis are at high risk of exposure to human rights violations.

Psychosis

Assessment and Management Guide

1. Does the person have acute psychosis?

- » Incoherent or irrelevant speech
- » Delusions
- » Hallucinations
- » Withdrawal, agitation, disorganized behaviour
- » Beliefs that thoughts are being inserted or broadcast from one's mind
- » Social withdrawal and neglect of usual responsibilities related to work, school, domestic or social activities

Ask the person or carer

- » When this episode began
- » Whether any prior episodes occurred
- » Details of any previous or current treatment

YES

If multiple symptoms are present, **psychosis** is likely.

If this episode is:

- » the first episode OR
- » a relapse OR
- » worsening of psychotic symptoms

it is an **acute psychotic episode**

- » Provide education to the person and carers about psychosis and its treatment. **» PSY 2.1**
- » Begin antipsychotic medication. **» PSY 3.1**
- » If available, provide psychological and social interventions, such as family therapy or social skills therapy. **» INT**
- » Facilitate rehabilitation. **» PSY 2.2**
- » Provide regular follow-up. **» PSY 2.3**
- » Maintain realistic hope and optimism.

NOTE: DO NOT prescribe anticholinergic medication routinely to prevent antipsychotic side-effects.

Rule out psychotic symptoms due to:

- » Alcohol or drug intoxication or withdrawal (*Refer to Alcohol use disorder/Drug use disorder module* **» ALC** and **» DRU**)
- » Delirium due to acute medical conditions such as cerebral malaria, systemic infections/sepsis, head injury

2. Does the person have chronic psychosis?

YES

If symptoms persist for more than 3 months

chronic psychosis is likely

- » Provide education to the person and carers. **» PSY 2.1**

IF THE PERSON IS NOT ON ANY TREATMENT, START TREATMENT AS FOR ACUTE PSYCHOTIC EPISODE.

- » Review and ensure treatment adherence.
- » If the person is not responding adequately, consider increasing current medication or changing it. **» PSY 3.1 and 3.2**
- » If available, provide psychological and social interventions such as family therapy or social skills therapy. Consider adding a psychosocial intervention not offered earlier, e.g. cognitive behavioural therapy if available. **» INT**
- » Provide regular follow-up. **» PSY 2.3**
- » Maintain realistic hope and optimism.
- » Facilitate rehabilitation. **» PSY 2.2**

Psychosis

PSY1

Assessment and Management Guide

3. Is the person having an acute manic episode?

Look for:

- Several days of:
  - Markedly elevated or irritable mood
  - Excessive energy and activity
  - Excessive talking
  - Recklessness
- Past history of:
  - Depressed mood
  - Decreased energy and activity

  (see Depression Module for details). **» DEP**

NOTE:

- *People who suffer only manic episodes (without depression) are also classified as having bipolar disorder.*
- *Complete recovery between episodes is common in bipolar disorder.*

YES

If yes, this could be bipolar disorder

» Exit this module and go to **Bipolar Disorder Module. » BPD**

4. Look for concurrent conditions

- Alcohol use or drug use disorders
- Suicide/self-harm
- Dementia
- Concurrent medical illness: *Consider especially signs/symptoms suggesting stroke, diabetes, hypertension, HIV/AIDS, cerebral malaria or medications (e.g. steroids)*

YES

If yes, then

» Manage both the psychosis and the concurrent condition.

Woman of child-bearing age?

- In the case of a pregnant woman, liaise with the maternal health specialist, if available, to organize care.
- Explain the risk of adverse consequences for the mother and her baby, including the risk of obstetric complications and psychotic relapse (particularly if medication is changed or stopped).
- Women with psychosis who are planning a pregnancy, pregnant, or breastfeeding should be treated with low-dose oral haloperidol or chlorpromazine.
- Avoid routine use of depot antipsychotics.

Psychosocial Interventions

2.1 Psychoeducation

» **Messages to the person with psychosis**
- the person's ability to recover;
- the importance of continuing regular social, educational and occupational activities, as far as possible;
- the suffering and problems can be reduced with treatment;
- the importance of taking medication regularly;
- the right of the person to be involved in every decision that concerns his or her treatment;
- the importance of staying healthy (e.g. healthy diet, staying physically active, maintaining personal hygiene).

» **Additional messages to family members of people with psychosis**
- The person with psychosis may hear voices or may firmly believe things that are untrue.
- The person with psychosis often does not agree that he or she is ill and may sometimes be hostile.
- The importance of recognizing the return/worsening of symptoms and of coming back for re-assessment should be stressed.
- The importance of including the person in family and other social activities should be stressed.
- Family members should avoid expressing constant or severe criticism or hostility towards the person with psychosis.
- People with psychosis are often discriminated against but should enjoy the same rights as all people.
- A person with psychosis may have difficulties recovering or functioning in high-stress working or living environments.
- It is best for the person to have a job or to be otherwise meaningfully occupied.
- In general, it is better for the person to live with family or community members in a supportive environment outside hospital settings. Long-term hospitalization should be avoided.

2.2 Facilitate rehabilitation in the community

Involve people with psychosis and their carers actively in the design, implementation and evaluation of these interventions.

» Coordinate interventions with health staff and with colleagues working in social services, including organizations working on disabilities.

» Facilitate liaison with available health and social resources to meet the family's physical, social and mental health needs.

» Actively encourage the person to resume social, educational and occupational activities as appropriate and advise family members about this. Facilitate inclusion in economic and social activities, including socially and culturally appropriate supported employment. People with psychosis are often discriminated against, so it is important to overcome internal and external prejudices and work toward the best quality of life possible. Work with local agencies to explore employment or educational opportunities, based on the person's needs and skill level.

» If needed and available, explore housing/assisted living support. Consider carefully the person's functional capacity and the need for support in advising and facilitating optimal housing arrangements, bearing in mind the human rights of the person.

2.3 Follow-up

» People with psychosis require regular follow-up.

» Initial follow-up should be as frequent as possible, even daily, until acute symptoms begin to respond to treatment. Once the symptoms have responded, monthly to quarterly follow-up is recommended based on clinical need and feasibility factors such as staff availability, distance from clinic, etc.

» Maintain realistic hope and optimism during treatment.

» At each follow-up, assess symptoms, side-effects of medications and adherence. Treatment non-adherence is common and involvement of carers is critical during such periods.

» Assess for and manage concurrent medical conditions.

» Assess for the need of psychosocial interventions at each follow-up.

Psychosis

Intervention Details

Pharmacological Interventions

3.1 Initiating antipsychotic medications

» For prompt control of acute psychotic symptoms, health-care providers should begin antipsychotic medication immediately after assessment. Consider acute intramuscular treatment only if oral treatment is not feasible. Do not prescribe depot/long-term injections for prompt control of acute psychotic symptoms.

» Prescribe one antipsychotic medication at a time.

» "Start low, go slow": Start with a low dose within the therapeutic range (see the antipsychotic medication table for details) and increase slowly to the lowest effective dose, in order to reduce the risk of side-effects.

» Try the medication at an optimum dose for at least 4–6 weeks before considering it ineffective.

» Oral haloperidol or chlorpromazine should be routinely offered to a person with psychotic disorder.

Table: Antipsychotic Medications

Medication:	Haloperidol	Chlorpromazine	Fluphenazine depot/long-acting
Starting dose:	1.5–3 mg	75 mg	12.5 mg
Typical effective dose (mg):	3–20 mg/day	75–300 mg/day*	12.5–100 mg every 2–5 weeks
Route:	oral/intramuscular (for acute psychosis)	oral	deep intramuscular injection in gluteal region
Significant side-effects:			
Sedation:	+	+++	+
Urinary hesitancy:	+	++	+
Orthostatic hypotension:	+	+++	+
Extrapyramidal side-effects:**	+++	+	+++
Neuroleptic malignant syndrome:***	rare	rare	rare
Tardive dyskinesia:****	+	+	+
ECG changes:	+	+	+
Contraindications:	impaired consciousness, bone marrow depression, pheochromocytoma, porphyria, basal ganglia disease	impaired consciousness, bone marrow depression, pheochromocytoma	children, impaired consciousness, parkinsonism, marked cerebral atherosclerosis

This table is for quick reference only and is not intended to be an exhaustive guide to the medications, their dosing and side-effects. Additional details are given in "Pharmacological Treatment of Mental Disorders in Primary Health Care" (WHO, 2009) (http://www.who.int/mental_health/management/psychotropic/en/index.html).

* Up to 1 g maybe necessary in severe cases.
** Extrapyramidal symptoms include acute dystonic reactions, tics, tremor, and cogwheel and muscular rigidity.
*** Neuroleptic malignant syndrome is a rare but potentially life-threatening disorder characterized by muscular rigidity, elevated temperature and high blood pressure.
**** Tardive dyskinesia is a long-term side-effect of antipsychotic medications characterized by involuntary muscular movements, particularly of the face, hands and trunk.

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PLOS | MEDICINE

Policy Forum

Grand Challenges in Global Mental Health: Integration in Research, Policy, and Practice

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This is one article in a five-part series providing a global perspective on integrating mental health.

Introduction

More than a decade ago, the World Health Organization's (WHO) World Health Report 2001 called for the integration of mental health into primary care, acknowledging the burden of mental, neurological, and substance use (MNS) disorders globally; the lack of specialized health care providers to meet treatment needs—especially in low- and middle-income countries (LMICs); and the fact that many people seek care for MNS disorders in primary care [1]. In 2012, the Global Burden of Disease (GBD) Study 2010 confirmed the still urgent need for attention to MNS disorders: over the past 20 years, the disability adjusted life years (DALYs) attributable to MNS disorders rose by 38%, and mental and behavioral disorders account for nearly one quarter of all years lived with a disability [2,3]. MNS disorders also contribute indirectly to mortality, through suicides and conditions like cirrhosis, which, in certain regions, both rank among leading causes of disease burden [2].

The GBD Study 2010 brought welcome news of reductions in the DALYs for communicable, maternal, neonatal, and nutritional disorders since 1990. This progress is due, in part, to coordinated, global cooperation to meet the Millennium Development Goals (MDGs) and, specifically, to achieve targets set for child survival, maternal health, and combatting HIV/AIDS and malaria by 2015. Crucial for the global public health community, investments in achieving the health-related MDGs catalyzed the development, testing, and implementation of effective health interventions for priority conditions and stimulated the development of packages of care that bundle effective interventions—whether for reduction of maternal or child mortality or for HIV care and treatment. Stakeholders recognize that "synergies in the health system must be pursued" [4], and that these packaged interventions can be delivered most effectively through integrated approaches to care [5].

The need for integrated care that addresses emerging priority conditions, like non-communicable diseases (NCDs), including MNS disorders, is acknowledged less frequently in the global context [6]. As a result of global population growth, aging, and epidemiologic and demographic transitions, NCDs account for more than 60% of deaths worldwide, with disproportionate rates of mortality among populations in LMICs [7]. Significantly, MNS disorders frequently occur throughout the course of many NCDs and infectious diseases, increasing morbidity and mortality [8–11]. Consequently, people suffering with co-morbid disorders, such as depression and HIV or post-traumatic stress disorder and coronary heart disease, risk poor outcomes for both disorders. Achieving desired outcomes for priority programs will be difficult without managing MNS disorders.

At a minimum, packages of care for MNS disorders should be parceled with effective interventions in primary care or other priority health delivery platforms. In truth, adequate attention to the public's health requires that this integration also occur in sectors beyond health (e.g., education, justice, welfare, and labor), through collaborative partnerships of government, non-governmental organizations (NGOs), and faith-based organizations, as well as in the implementation of global health and development policy.

The Grand Challenge of Integrating Care for MNS Disorders with Other Chronic Disease Care

Despite the increasing burden of MNS disorders around the world and their frequent co-morbidities, affected individuals often lack access to mental health care in high-, middle-, and low-income countries [12]. Inadequate investments in mental health care are partially responsible. Costs associated with mental illness

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Abbreviations: DALY, disability adjusted life year; GBD, global burden of disease; GCGMH, Grand Challenges in Global Mental Health; LMIC, low- and middle-income country; MNS, mental, neurological, and substance use; mhGAP, Mental Health Gap Action Programme; MDG, Millennium Development Goal; NCD, non-communicable disease; NIMH, National Institute of Mental Health; NGO, non-governmental organization; WHO, World Health Organization.

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Key Research Questions for GMH

- the relevance of existing nosological systems and their impact on help-seeking, illness course and treatment response
- development of assessment approaches sensitive to local idioms of distress
- understanding and supporting local modes of coping, resilience and recovery
- evaluating the impact of mental health interventions in social/ cultural context
- assessing the costs and benefits of globalized and indigenous healing systems

Dilemmas of the GMH Movement

- Recent debates on global mental health have raised questions about the goals, methods, and consequences of current approaches.

- These critiques emphasize the difficulties and potential dangers of applying Western categories, concepts, and interventions given the many different ways that culture shapes illness experience.

- The concern is that in the urgency to address disparities in global health, ways of framing problems and intervening that are not culturally consonant will be exported to local populations with negative effects.

Critiques of the GMH Logic

Critics of the GMH movement challenge each of the core assumptions:

1. estimates of the prevalence and toll of mental health problems in most parts of the world are based on uncertain/questionable extrapolation that lead to inflated or misleading figures;

2. economic inequality, structural violence, war and conflict on both local and global scales are far more important determinants of health than the types of problems recognized in international mental health mental health;

3. framing the disparities in terms of a treatment gap privileges mental health services and interventions as an appropriate response by mental health professionals is self-serving and ignores community-based and grassroots approaches;

4. evidence-based practices developed in Western countries may not be culturally appropriate, feasible, or effective in other contexts. Moreover, the demand to scale-up evidence-based practices may pre-determine the types of intervention available.

Culture and Context in GMH

Cultural considerations contribute to all four arguments:

1. the ways that problems are categorized and counted depends on culturally-rooted systems of psychiatric nosology

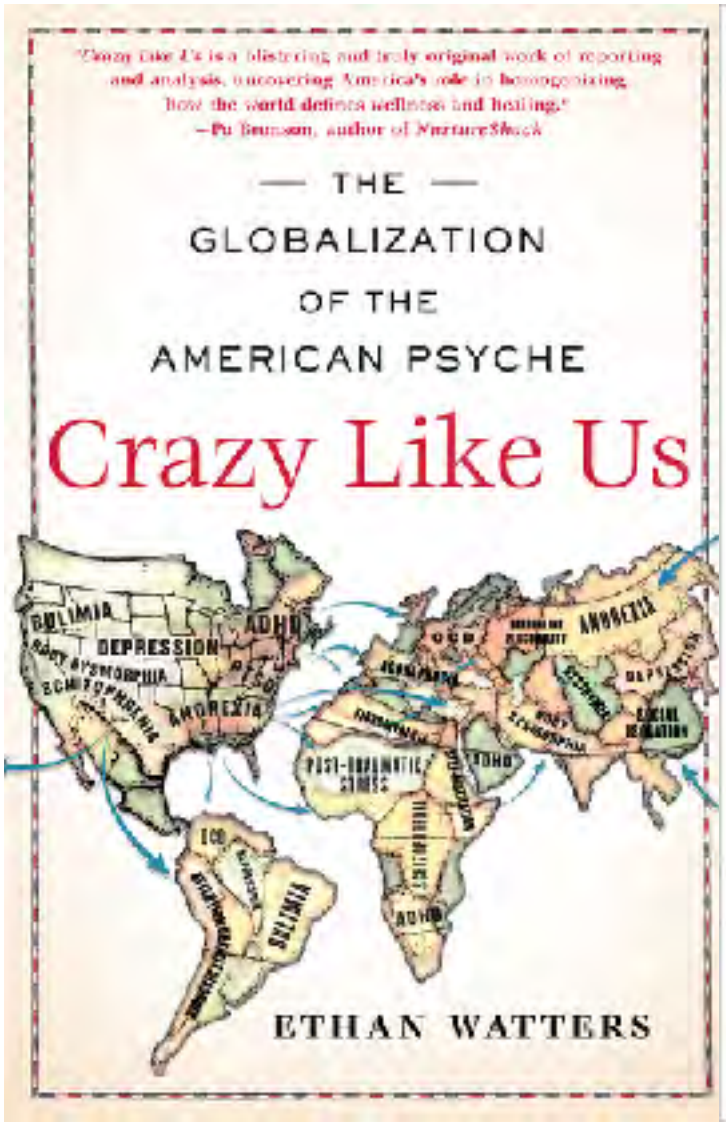
2. the social determinants of health are depend on culturally mediated distinctions between groups that vary across societies

3. the local response to suffering is embedded in cultural systems of meaning and healing that are part of the religious, spiritual and moral fabric of communities and societies

4. the production of evidence is shaped by cultural assumptions, and the fit (or adaptability) of interventions across cultures depends crucially on the generalizability of these concepts, values and practices.

Persistent Controversies

- varying levels of agreement about the universal applicability of existing diagnostic categories and treatments
- varying levels of agreement about the quality of available interventions and the evidence as to what works
- concern about the type of outcomes measured and their relevance to different social and cultural contexts and
- concern about the need to protect and promote, local, indigenous methods of helping, healing and recovery.


"Crazy Like Us is a blistering and truly original work of reporting and analysis, uncovering America's role in homogenizing how the world defines wellness and healing."
—Po Bronson, author of NurtureShock
THE
GLOBALIZATION
OF THE
AMERICAN PSYCHE
Crazy Like Us
BULIMIA
DEPRESSION
ADHD
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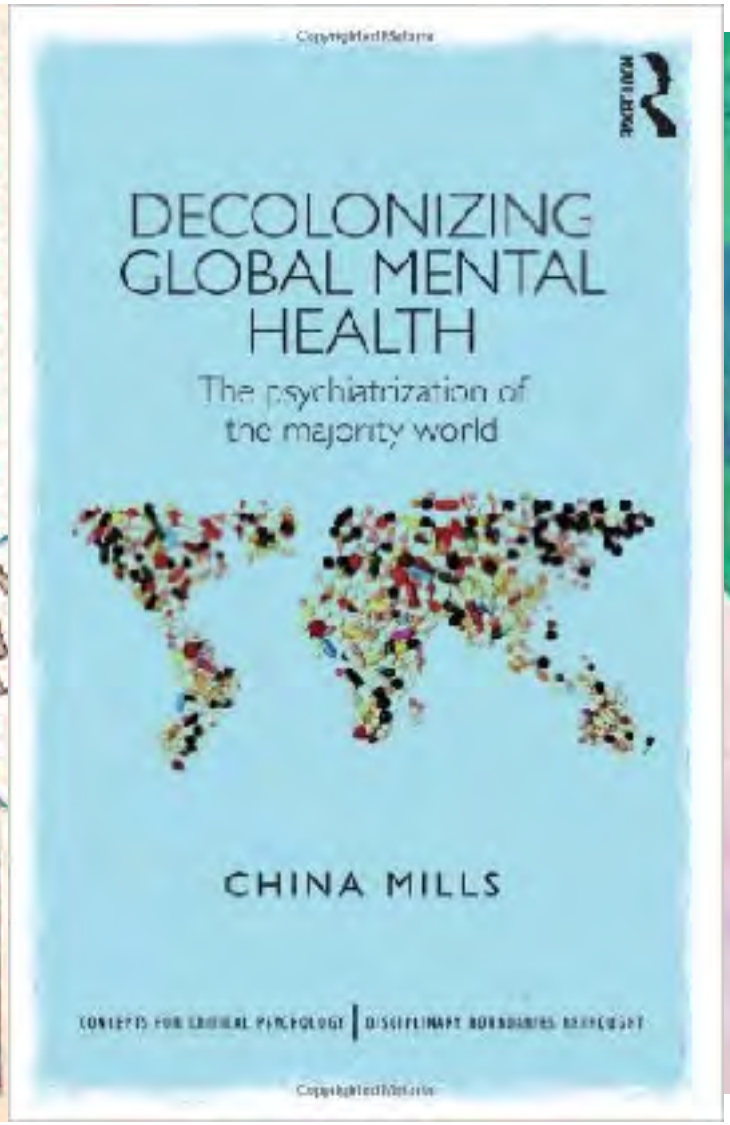
DECOLONIZING
GLOBAL MENTAL
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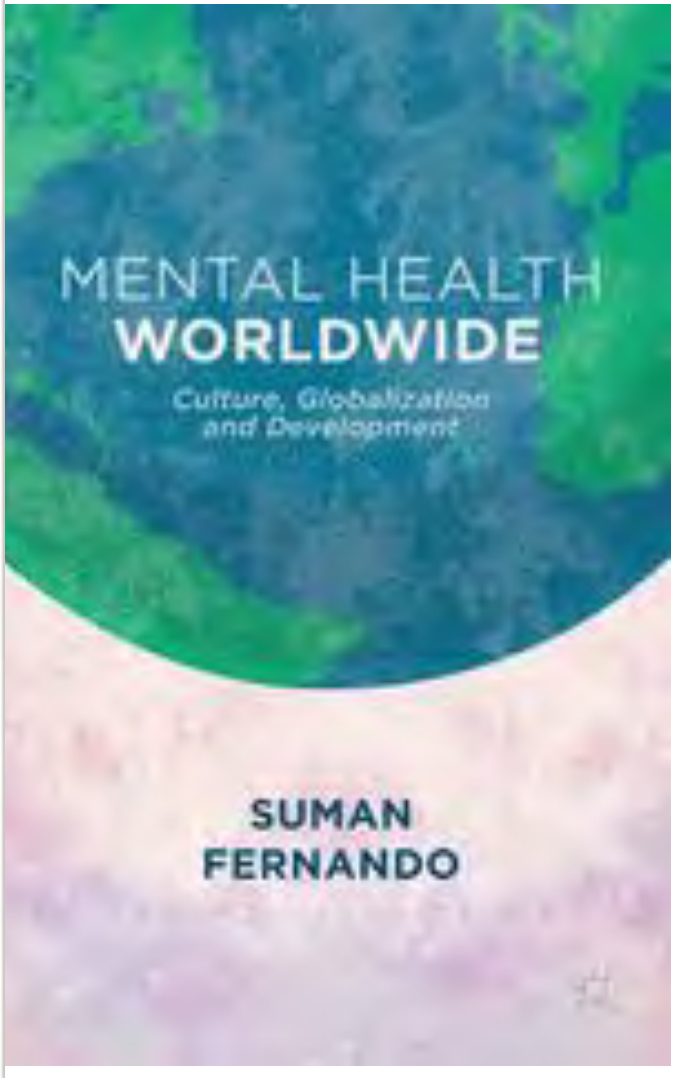
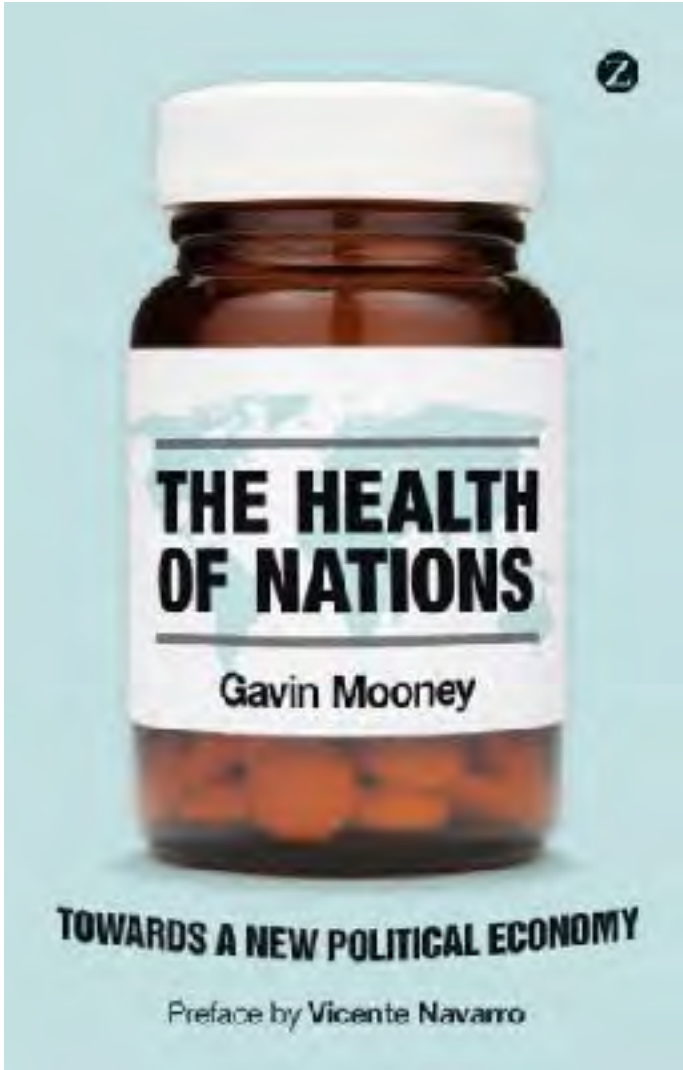
The psychiatrization of
the majority world
CHINA MILLS


MENTAL HEALTH
WORLDWIDE
Culture, Globalization
and Development
SUMAN
FERNANDO

Social Determinants in Global Mental Health

- GMH programs have tended to downplay addressing SDH in favour of focus on mental health services
- this reflects the individualistic orientation of biomedicine
- it also reflects the priorities of health funders and policy makers and national and international levels
- the result privileges mental health services and gives less emphasis to primary prevention, grass-roots interventions, and community development



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transcultural psychiatry

Editorial

Toward a new architecture for global mental health

Laurence J. Kirmayer and Duncan Pedersen
McGill University

Abstract

Current efforts in global mental health (GMH) aim to address the inequities in mental health between low-income and high-income countries, as well as vulnerable populations within wealthy nations (e.g., indigenous peoples, refugees, urban poor). The main strategies promoted by the World Health Organization (WHO) and other allies have been focused on developing, implementing, and evaluating evidence-based practices that can be scaled up through task-shifting and other methods to improve access to services or interventions and reduce the global treatment gap for mental disorders. Recent debates on global mental health have raised questions about the goals and consequences of current approaches. Some of these critiques emphasize the difficulties and potential dangers of applying Western categories, concepts, and interventions given the ways that culture shapes illness experience. The concern is that in the urgency to address disparities in global health, interventions that are not locally relevant and culturally consonant will be exported with negative effects including inappropriate diagnoses and interventions, increased stigma, and poor health outcomes. More fundamentally, exclusive attention to mental disorders identified by psychiatric nosologies may shift attention from social structural determinants of health that are among the root causes of global health disparities. This paper addresses these critiques and suggests how the GMH movement can respond through appropriate modes of community-based practice and ongoing research, while continuing to work for greater equity and social justice in access to effective, socially relevant, culturally safe and appropriate mental health care on a global scale.

Keywords

Basic Issues

- Global mental health exists against the historical background and ongoing reconfigurations of colonialism, postcolonialism, neocolonialism, and the contexts of globalization
- psychologization and psychiatrization play an important role in emerging forms of personhood in modernity
- psychiatric institutions contribute to social control, regulation, and legitimation not only through carceral functions but increasingly through epistemic regimes of evidence and authority
- the process of making global mental health a movement aims to mobilize resources but raises a set of new political, organizational and conceptual questions

Individual Clinical Problems

At the level of *individuals and families* in clinical care, negative effects may occur…

- through diagnosis and assessment that uses nosological systems that are not appropriate for local cultural contexts, resulting in misdiagnosis
- by failing to recognize relevant personal and social problems that demand solutions other than mental health treatment
- by applying treatments of uncertain value
- by undermining local modes of understanding, explaining and effectively coping with affliction
- by stigmatizing individuals through associations with psychiatric illness

Health Systems & Community Problems

At the level of *health systems, institutions, communities and populations*, negative effects may occur…

- by displacing attention from social structural and political economic determinants of mental health toward their distal mental health effects on individuals;
- by adopting the economic agendas of multinational pharmaceutical corporations or other interests that may ultimately conflict with public health goals;
- by ignoring, invalidating or displacing indigenous systems of mental health promotion and healing that are part of the social fabric and resilience of local communities;
- by undermining community autonomy and self direction in favour of professional, technocratic, expert-driven approaches associated with mental health services.

Adeponle *et al. Int J Ment Health Syst (2017) 11:27*
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RESEARCH Open Access

Perinatal depression in Nigeria: perspectives of women, family caregivers and health care providers

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Abstract

Background: Perinatal maternal depression is common and undertreated in many sub-Saharan African countries, including Nigeria. While culture shapes the social determinants and expression of depressive symptoms, there is a dearth of research investigating these processes in African contexts.

Methods: To address this gap, we conducted in-depth interviews with 14 women with perinatal depression, 14 of their family caregivers and 11 health providers, using the *McGill Illness Narrative Interview* as part of a larger trial of a stepped-care intervention. Interpretation of themes was guided by cultural constructivist and critical anthropological perspectives that situate perinatal depression in its complexity as a disorder that is embedded in webs of social relations and embodied practices.

Results: Study respondents used idioms of distress that identified perinatal conditions that consist of somatic, affective, cognitive and behavior symptoms found in depressive disorders. Respondents viewed mental health problems in the perinatal period as tied to sociomoral concerns over gender roles and women's position within the household. Conflict between women's effort to be assertive to address interpersonal problems, while needing to be seen as non-aggressive contributed to their distress. Causal explanations for depression included husband's lack of care, family problems, "spiritual attack", having a female child when a male child was desired, and not resting sufficiently after childbirth. Guilt about breaching social norms for women's conduct contributed to self blame, and feelings of shame.

Conclusions: Clinical assessment and interventions as well as public health prevention strategies for perinatal depression in global mental health need to consider local social contexts and meanings of depression, which can be explored with narrative-based methods.

Keywords: Nigeria, Perinatal depression, Qualitative interviews, Illness explanatory models

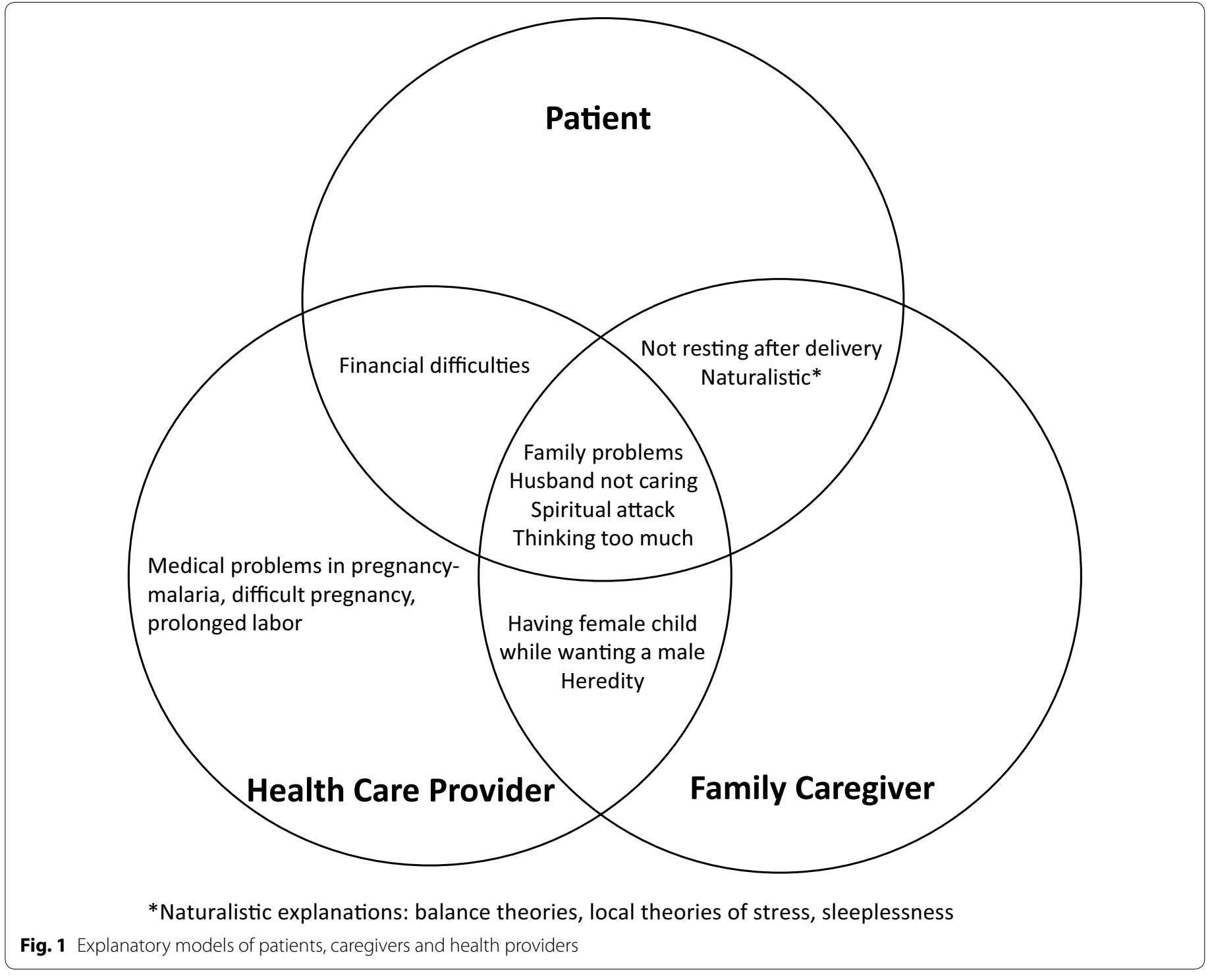

Fig. 1 Explanatory models of patients, caregivers and health providers

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Culture and depression in global mental health: An ecosocial approach to the phenomenology of psychiatric disorders

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Review

1. Introduction: The global burden of depression

Depression is a major focus of concern in global mental health, with epidemiological surveys indicating high prevalence rates

Steel et al., 2014).

In a useful contribution, Haroz and colleagues (Haroz et al., 2017) reviewed the qualitative literature on cultural variations in depression to gauge the extent to which current diagnostic criteria fit the experience of people in diverse contexts. They found significant cultural variation and call for an expanded research program to explore the meaning and significance of these cultural differences for our understanding of mental health. This is crucial for current efforts to address global inequities in mental health and to make sense of claims of a global "epidemic" of depression (Baxter et al., 2014).

In this commentary, we examine the methods and findings of Haroz and colleagues' study and discuss implications for future research on depression and the development of interventions in global mental health.

2. Thinking inside the box: qualitative studies of the symptoms of depression

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REVIEW Open Access

Considering culture, context and community in mhGAP implementation and training: challenges and recommendations from the field

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Abstract

Background: Major efforts are underway to improve access to mental health care in low- and middle-income countries (LMIC) including systematic training of non-specialized health professionals and other care providers to identify and help individuals with mental disorders. In many LMIC, this effort is guided by the mental health Gap Action Programme (mhGAP) established by the World Health Organization, and commonly centres around one tool in this program: the mhGAP-Intervention Guide.

Objective: To identify cultural and contextual challenges in mhGAP training and implementation and potential strategies for mitigation.

Method: An informal consultative approach was used to analyze the authors' combined field experience in the practice of mhGAP implementation and training. We employed iterative thematic analysis to consolidate and refine lessons, challenges and recommendations through multiple drafts. Findings were organized into categories according to specific challenges, lessons learned and recommendations for future practice. We aimed to identify cross-cutting and recurrent issues.

Results: Based on intensive fieldwork experience with a focus on capacity building, we identify six major sets of challenges: (i) cultural differences in explanations of and attitudes toward mental disorder; (ii) the structure of the local health-care system; (iii) the level of supervision and support available post-training; (iv) the level of previous education, knowledge and skills of trainees; (v) the process of recruitment of trainees; and (vi) the larger socio-political context. Approaches to addressing these problems include: (1) cultural and contextual adaptation of training activities, (2) meaningful stakeholder and community engagement, and (3) processes that provide support to trainees, such as ongoing supervision and Communities of Practice.

Conclusion: Contextual and cultural factors present major barriers to mhGAP implementation and sustainability of improved services. To enable trainees to effectively apply their local cultural knowledge, mhGAP training needs to: (1) address assumptions, biases and stigma associated with mental health symptoms and problems; (2) provide an explicit framework to guide the integration of cultural knowledge into assessment, treatment negotiation, and delivery; and (3) address the specific kinds of problems, modes of clinical presentations and social predicaments seen in the local population. Continued research is needed to assess the effectiveness these strategies.

Keywords: mhGAP, Global Mental Health, Primary care, Integration, Task shifting, Cultural adaptation, Implementation

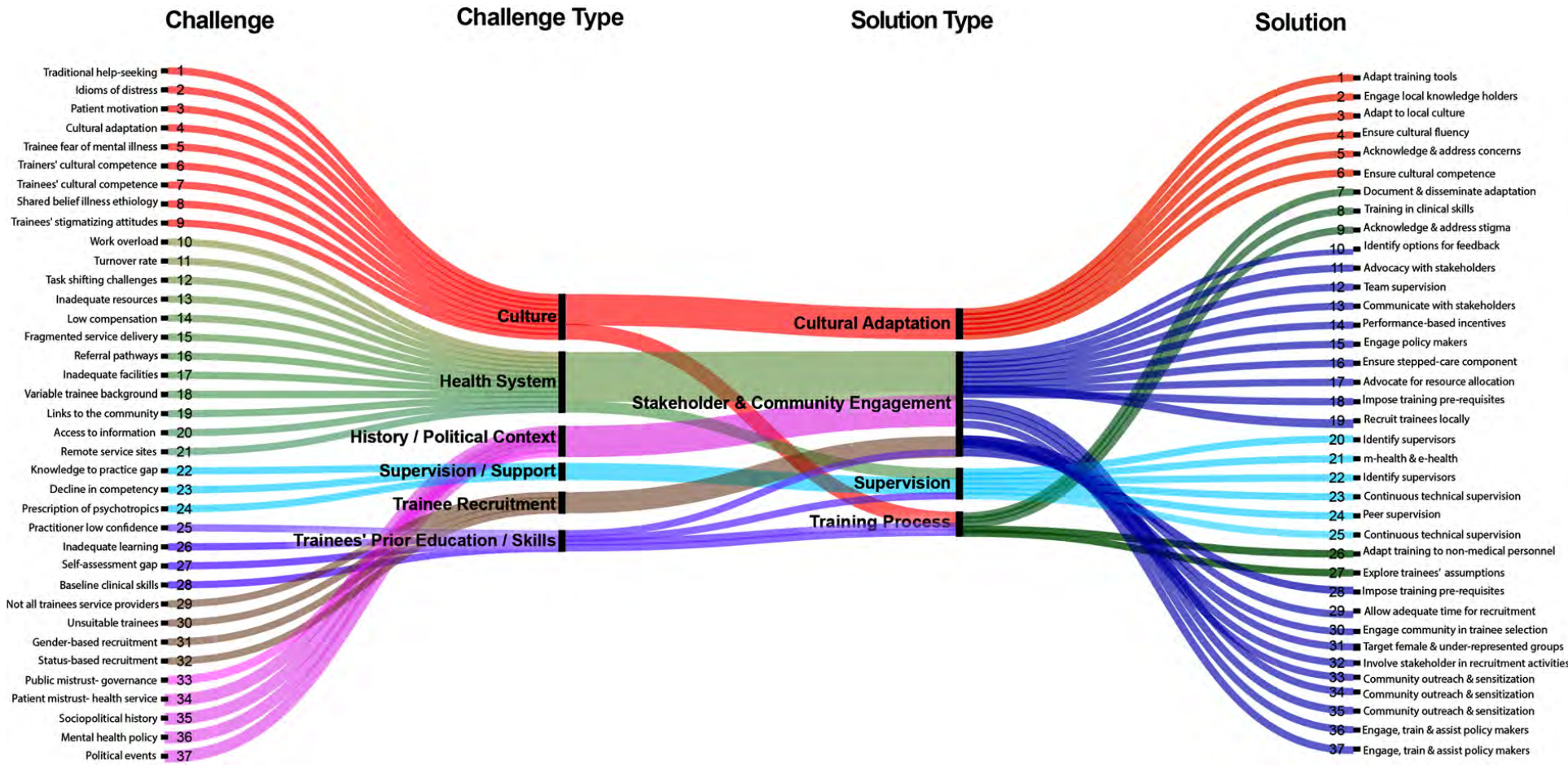

Fig. 1 Correspondence of type of challenges in mhGAP training and implementation and potential solutions

Toward an Ecosocial Psychiatry

Abstract

Social psychiatry is grounded in the recognition that we are fundamentally cultural beings. To advance the field, we need integrative theory and practical tools to better understand, assess, and intervene in the social-ecological cultural systems that constitute our selves and personhood. Cognitive science supports the view that mental processes are intrinsically social, embodied, and enacted through metaphor, narrative, and discursive practices. The circuits of the mind, therefore, extend beyond the brain to include our interactions with others through bodily and verbal communication. This ecosocial view of mind, brain, and culture calls for a shift in perspective from a psychiatry centered on brain circuitry and disorders toward one that recognizes social predicaments as the central focus of clinical concern and social systems or networks as a crucial site for explanation and intervention. The ecosocial perspective insists that we consider the powerful effects of structural violence and social inequality as key determinants of health. Social systems also have their own dynamics which can amplify inequities or provide sources of resilience. These social processes are framed, mediated, and maintained by cultural narratives, models, and metaphors. Hence, cultural analysis and critique must be foundational to social psychiatry. This opens the door to a creative engagement with human diversity in all its forms.

Keywords: *Culture, ecosocial, psychiatry*

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Introduction

Social psychiatry is grounded in the recognition that we are fundamentally cultural beings.[1] Our brains are designed to acquire culture to navigate a social world, find support from others, and cooperate to construct our own ecosocial niche. For the last 50,000 years, we have been co-evolving with those niches, developing a vast array of cultures, languages, and forms of communal life to adapt to the demands of varied environments. This sociality is reflected in the architecture of our brains, which are organized to process social information, but especially in their plasticity, which allow us to acquire culture over decades of development. The brain is remodeled and rewired in response to the ways that we use it, with the result that we carry cultural knowledge, values, and skills within us in our personal storehouse of memory and capacity to respond to situations. However, most of the culture remain without, in the social environment, structured as affordances to which we respond based on our social position, norms, expectations, and aspirations.[2]

Cognitive science increasingly supports the view, first tendered by phenomenology, that mental processes are intrinsically social. The circuits of the mind extend out into the world, through our tools, discourse, practices, and institutions that enable cooperation. The world presents itself to us in terms of its affordances for action and perception, and these affordances are preeminently social and cultural. The collective knowledge, tools, and insights of previous generations are available to us through archives, and we scaffold more complex cognition on this cultural history, which is sedimented in language and present to us in our institutions and practices. In effect, we are able to extend the reach of our thoughts by thinking through other minds.[3] All of this makes social psychiatry not simply an "add-on" or supplement to biological psychiatry, but a necessity if we wish to understand the basic mechanisms of mental disorders and their effective treatment.[4]

This social view of the brain has received new precision through the current work

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